Completion Instructions for DCH-0078
Request to Add, Terminate or Change Other Insurance

Form DCH-0078 is a formal request for change in other insurance status and must be submitted by the Medicaid provider, Medicaid Health Plan, Local Health Department or the Department of Human Services caseworker to add, terminate, or change beneficiary insurance information other than Medicaid.

INSTRUCTIONS:

- PRINT or TYPE
- Place a check mark in the appropriate "Add," "Terminate," or "Change" field
- Sections denoted by * are mandatory to be completed
- Attach clear copy of insurance card (front and back) when adding insurance (if available)
- Retain a COPY in beneficary file
- Submit form and applicable attachments via:

Fax Number: **517-346-9817**

E-mail: TPL_Health@michigan.gov

Mail to: Michigan Department of Community Health
Third Party Liability Division
Bureau of Financial Management
PO Box 30479
Lansing MI 48909

Allow 7-10 business days for the request to be completed. To verify the request has been completed, view the beneficiary eligibility information in the Community Health Automated Medicaid Processing System (CHAMPS).

AUTHORITY: Title V and Title XIX of the Social Security Act.

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.

Michigan Department of Community Health

REQUEST TO ADD, TERMINATE OR CHANGE OTHER INSURANCE

☐ **ADD** ☐ **TERMINATE** ☐ **CHANGE**

SECTION 1 – Medicaid Provider/Medicaid Health Plan/LHD/DHS Caseworker Information *

Requestor Name	Date	County/Local Health Department
Phone Number ( )	FAX Number ( )	Case Number (if available)

SECTION 2 – List of Beneficiaries/Clients to Add, Terminate or Change Insurance *

Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID
Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID
Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID

SECTION 3 – Policyholder Information *

Policyholder Name (Last, First, Middle)	Date of Birth	Employer Name
Social Security Number		Employer City and State
Type of Coverage (use an "X") ☐ **Traditional** ☐ **Managed Care** (Preferred Provider Organization, Health Maintenance Organization, Point of Service)		
Health Insurance Company Name	Group / Policy Number	Certificate / Contract Number
Pharmacy Insurance Name	Dental Insurance Name	Vision Insurance Name

SECTION 4 – Reason For Change

☐ **Divorce** ➔ Date of Divorce		☐ **Military Discharge** ➔ Date of Discharge	
☐ **Coverage Termination** ➔ Date of Termination		☐ **Employment Termination** ➔ Date of Termination	
☐ **OTHER** (explain): ➔ Date of Change	Reason:		

Attachments: Attach documentation to substantiate a request to terminate or change insurance coverage, such as a letter from an insurance company or employer.

COMMENTS:

SUBMIT:

MDCH - THIRD PARTY LIABILITY DIVISION

FAX (517) 346-9817

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